Insurance Institute
of Michigan

April 13, 2011

The Honorable Roger Kahn
Senate Appropriations Committee
Michigan Senate
Lansing, Michigan 48909

Dear Senator Kahn:

On behalf of the members of the Insurance Institute of Michigan, I write to express our opposition to Senate Bill 311 as introduced and before this committee. This legislation would subject automobile no-fault carriers to the mandatory download of volumes of policyholder and claims information to the Department of Community Health.

The intent of this legislation is assist the Department of Community Health with its obligation to insure that Medicaid is the payer of last resort, and that any outstanding medical benefits are exhausted before Medicaid funds are utilized for the payment of health care benefits.

It has been suggested that federal law mandates such disclosures to the department. Our research indicates that is not the case, and that it is the obligation of the state agencies to inquire of the applicants for assistance whether other parties may be liable for the medical services sought. This is far from a mandatory download requirement on the part of Michigan's no-fault automobile insurance carriers.

I have attached a letter to the Honorable Bob Constan from June 17, 2010, outlining our opposition and research to a similar measure considered during the 95th Michigan Legislative session. This establishes our position that there is no federal mandate, and the proposed massive download of data in most instances will not provide the information necessary to identify the existence of a financially responsible health care policy.

The property and casualty insurance industry recognizes its obligation to pay all legitimate claims as provided for by law. We are currently in discussions with representatives of the Department of Community Health and the bill sponsor in order to find an appropriate process or mechanism to quickly and cost effectively identify those carriers with such obligations.

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We believe that Senate Bill 311 is both ineffective and unnecessary to accomplish the stated goal of proper coordination of Medicaid payments and any outstanding automobile no-fault benefits.

We respectfully request your opposition to passage of this legislation at this time.

Sincerely,

Peter A. Kuhnmuench
Executive Director

Attachment (1)

Insurance Institute
of Michigan

June 17, 2010

The Honorable Bob Constan
House Government Operations Committee
Michigan House of Representatives
Lansing, Michigan 48909

Dear Rep. Constan:

On behalf of the members of the Insurance Institute of Michigan, I write to express our strong opposition to House Bill 6231 which requires auto insurers to download untold volumes of policyholder and claims information on a monthly basis to the Michigan Department of Community Health ("MDCH").

The primary argument behind House Bill 6231 is that federal law mandates that states pass laws regarding insurer file sharing to make sure that Medicaid is the payer of last resort. This mandated file sharing theoretically allows state Medicaid programs, here run by MDCH, to match the received list of names against their database of known Medicaid recipients. If MDCH finds a match, and Medicaid has already paid health care provider benefits on behalf of the particular claimant, Medicaid can seek restitution from the private insurer who should have otherwise paid that portion of the claim.

In our research so far of related federal law and regulations, including documents provided by the MDCH, we do not find such file sharing mandates. Further, as outlined below, we believe the proposal's inclusion of auto insurers in existing health insurer file sharing mandates is redundant and unnecessary; file sharing mandates would be an enormous burden to auto insurers but provide little benefit to MDCH; contradictory "look-back" time frames conflict with existing no-fault law; insurers' privacy concerns continue; and better, more cost effective alternatives exist for MDCH to access relevant auto insurer claims information.

Our concerns with House Bill 6231 are as follows:

1. Federal law does not require states to adopt mandates for auto insurers to download information:

This issue initially arose from the passage in Congress of the federal Deficit Reduction Act of 2005. Section 6035 of that Act added language to the federal Social Security Act

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requiring states to provide assurances to the federal government that each state has in effect:

> laws requiring health insurers, including self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, *or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service,* as a condition of doing business in this State, to –
>
> (i) provide with respect to individuals who are eligible for, or are provided, medical assistance under the State plan, upon the request of the State, information to determine during what period the individual or their spouses or their dependents may be (or may have been) covered by a health insurer and the nature of the coverage that is or was provided by the health insurer (including the name, address, and identifying number of the plan) in a manner prescribed by the Secretary . . . .
> (42 USC Sec. 1396a(a)(25)(I); Emphasis added)

In 2006, MDCH chose to broadly interpret this language to include not only traditional health carriers, but auto insurers as well. This broad interpretation was based upon the "catch all" language found in italics at the end of the above paragraph (I). But the intent of this language appears clear to us to include only health insurers in all their structural permutations, not to include other types of carriers.

Further, if the above subsection is considered in context, the federal mandates do not require data downloads, but do require that state agencies specifically:

> take all reasonable measures to ascertain the legal liability of third parties . . . including . . . the collection of sufficient information (as specified by the Secretary in regulations) to enable the State to pursue claims against such third parties, *with such information being collected at the time of any determination or redetermination of eligibility for medical assistance* . . . .
> (42 USC Sec. 1396a(a)(25)(A); emphasis added)

The federal rules regarding the identification of liable third parties, referenced above, similarly require state agencies to inquire of applicants for assistance whether other parties may be liable for the medical product or service sought.

(a) The agency must take reasonable measures to determine the legal liability of the third parties who are liable to pay for services furnished under the plan. At a minimum, such measures must include the requirements specified in paragraphs (b) through (k) of this section, unless waived under paragraph (l) of this section.
(b) (1) If the Medicaid agency determines eligibility for Medicaid, it must, during the initial application and each redetermination process, *obtain*

> *from the applicant or recipient* such health insurance information as would be useful in identifying legally liable third party resources so that the agency may process claims under the third party liability payment procedures specified . . .
> (42 C.F.R. 433.138; emphasis added)

To our knowledge, the remainder of the related federal law and rules provide a structure for the process on how state agencies must recoup funds once they have determined the liability or potential liability of a third party and further that those identified third parties cooperate with state agencies in those circumstances.

Nothing in federal law or regulations that we are aware of requires states pass laws mandating third party data downloads for Medicaid matching purposes.

2. Our inclusion in the bill is redundant and unnecessary:

By auto insurance industry estimates, over 75% of all auto policies are written on a "coordinated" basis, meaning that the policyholder has other health coverage which is primary on any auto accident-related injury. In these cases, for example, if John Doe with a coordinated auto insurance policy is injured in an auto accident, his health insurer would pay the claim from the first dollar through the end of the policy coverage.

So, for example, if House Bill 6231 were to pass in its current form, John Doe's health plan administrator would submit John Doe's name to MDCH for any match. If there is a match, the health insurer would reimburse Medicaid, and thereafter Medicaid would know not to pay further on the claim. Some time later, once John Doe's health insurance coverage runs out, John Doe's auto insurer's coverage would kick in to pay any remaining benefits necessary stemming from the same injury. Again, under the bill as currently drafted, John Doe's auto insurer would now send John Doe's name to MDCH. But MDCH was already notified of John Doe by the health carrier and any improper Medicaid payment has already been cleared up.

Further, whether a particular circumstance involves a coordinated policy or not, we believe relative reimbursement rates in the marketplace drive medical providers to seek private insurance coverage prior to submission of a claim to Medicaid. It is a well known fact that reimbursement rates among private insurers, particularly auto no-fault insurers, are considerably higher than Medicaid reimbursement rates. Once medical providers know of the origin of the injury, they know immediately, and indeed have a strong economic incentive, to seek coverage from a private policy.

This bill forces auto insurers to spend considerable amounts of time and resources to comply with a system of reporting to MDCH information that will largely be redundant and unnecessary, and perhaps similarly burdensome to MDCH.

3. The legislation would create enormous administrative burdens:

Auto insurers are faced with an obviously considerable expenditure of funds to comply with this legislation. They have no similar reporting requirements to any state department, including our own regulator the Office of Financial & Insurance Regulation, and have no relationship with MDCH or any idea how to interface with MDCH.

As for any cost/benefit analysis, MDCH has yet to provide a formal breakdown of what portion of the FY' 11 MDCH budget is based upon the inclusion of auto insurers in file sharing mandates. We suspect the amount is very small, particularly relative to the cost of compliance.

4. Contradictory look-back time frames:

House Bill 6231 provides for a six-year "look-back" within which Medicaid can enforce its right of restitution from the private insurance carrier. MCL 500.3145(1) of the Michigan insurance code provides, however, that claimants for auto insurance benefits cannot recover benefits for any portion of a loss that was incurred more than one year prior to the date on which an action was commenced.

Indeed, in *Liptow v Michigan Dept of Community Health and State Farm*, the Michigan Court of Appeals in a published decision dated October 24, 2006, held that MDCH could not seek reimbursement from State Farm for Medicaid benefits paid to Ms. Liptow more than one year prior to the date the suit was filed.

5. Privacy Concerns:

Auto insurers have strong concerns about the impact of this legislation on compliance with existing state and federal privacy laws. And with companies essentially being forced to submit to MDCH who their customers are, they have very strong concerns over the release of what is otherwise closely held, proprietary information without any assurance of the ongoing protection of the confidentiality of this information from Freedom of Information Act Requests, or any restrictions on storage or other uses.

6. Better Alternatives Exist for MDCH:

The Insurance Institute of Michigan and other representatives of the auto insurance industry in Michigan have met with MDCH and offered to work cooperatively to find the best method to enable MDCH to comply with the federal mandates to make sure that Medicaid is not paying on claims that are otherwise covered by existing private insurance coverage.

Presently, no-fault auto insurers are under specific federal statutory mandate to report certain auto insurance claims information to the Centers for Medicare and Medicaid Services (CMS) to meet federal Medicare Secondary Payer requirements. This mandate dates back to 2007 and CMS has been working with auto insurers at the national level

since then to develop time frame, format, data field, and transmission protocols for eventual use in meeting these reporting requirements.

This has been a very time consuming, technical, and expensive endeavor for both CMS and the industry, with costs already exceeding $1 million for certain individual companies. The program is now in testing phase; current projections have the program going live in January 2011. More information on this program can be found at: http://www.cms.gov/mandatoryinsrep/04_whats_new.asp?

Once this process of insurer downloads is complete for federal Medicare match purposes, it would seem logical that MDCH (beyond meeting the specific mandates of federal statute and regulation to ask applicants for Medicaid benefits for alternative coverage information) could simply and cost-effectively access this same information for matching against existing Medicaid rolls.

Conclusion

We appreciate MDCH's concerns about costs and the possibility of inadvertently paying for what would otherwise be a covered claim under an auto insurance policy, and the insurance industry is certainly committed to paying all covered claims. However, due to the above concerns we at this time strongly oppose the mandates of House Bill 6231 and respectfully ask that the House Government Operations Committee not report the bill in its current form.

Thank you in advance for your attention to this matter. Please let me know if you have any questions or comments.

Sincerely,

Dyck E. Van Koevering
General Counsel

/attachments

cc: Members, House Government Operations Committee

HOUSE BILL No. 6231

June 1, 2010, Introduced by Reps. Constan, Miller, Bettie Scott, Switalski, Geiss, Kandrevas, Scripps, Liss, Walsh and Young and referred to the Committee on Government Operations.

A bill to amend 2006 PA 593, entitled

"An act to provide for the sharing of certain health care coverage information; to provide for the powers and duties of certain departments and agencies; and to provide penalties and fines,"

by amending sections 1, 3, and 7 (MCL 550.281, 550.283, and 550.287) and by adding section 6.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 1. As used in this act:

(A) "CHILD SUPPORT ORDER" MEANS A COURT ORDER THAT REQUIRES A NAMED INDIVIDUAL TO OBTAIN HEALTH COVERAGE FOR A DEPENDENT.

(B) ~~(a)~~ "Department" means the department of community health.

(C) ~~(b)~~ "Entity" means a health insurer; a health maintenance organization; a nonprofit health care corporation; a managed care corporation; a preferred provider organization; an organization

HOUSE BILL No. 6231

operating pursuant to the prudent purchaser act, 1984 PA 233, MCL 550.51 to 550.63; a self-funded health plan; a professional association, trust, pool, union, or fraternal group, offering health coverage; a system of health care delivery and financing operating pursuant to section 3573 of the insurance code of 1956, 1956 PA 218, MCL 500.3573; and a third party administrator. **EFFECTIVE JANUARY 1, 2011, ENTITY INCLUDES A PARTY LEGALLY RESPONSIBLE FOR PAYMENT OF A HEALTH CARE CLAIM ARISING OUT OF CHAPTER 31 OF THE INSURANCE CODE OF 1956, 1956 PA 218, MCL 500.3101 TO 500.3179.**

(D) ~~(c)~~ "Medical assistance" means the medical assistance program administered by the state under the social welfare act, 1939 PA 280, MCL 400.1 to 400.119b.

(E) ~~(d)~~ "Qualified health plan" means that term as defined in section 111i of the social welfare act, 1939 PA 280, MCL 400.111i.

Sec. 3. (1) An entity shall provide on a monthly basis to the department, in a format determined by the department, information necessary to enable the department or entity to determine whether a health coverage recipient of the entity is also a medical assistance recipient **OR A CHILD SUPPORT ORDER DEPENDENT OR IS ALSO SUBJECT TO A CHILD SUPPORT ORDER. AN ENTITY SHALL RESPOND TO ANY DEPARTMENT INQUIRY CONCERNING A REQUEST FOR HEALTH COVERAGE VERIFICATION.**

(2) If a health coverage recipient of the entity is also a medical assistance recipient, the entity shall do all of the following by not later than 180 days after the department's request:

(a) Pay the department for, or assign to the department any right of recovery owed to the entity for, a covered health claim for which medical assistance payment has been made.

(b) Respond to any inquiry by the department concerning a claim for payment for any health care item or service that is submitted not later than 3 years after the date the health care item or service was provided.

(3) An entity shall not deny a claim submitted by the department solely on the basis of the date of submission of the claim, **THE METHOD OF THE SUBMISSION OF THE CLAIM,** the type or format of the claim form, or a failure to present proper documentation at the time the health care item or service that is the basis of the claim was provided so long as both of the following apply:

(a) The claim is submitted to the entity within 3 years of the date that the health care item or service that is the subject of the claim was provided.

(b) Any action by the state to enforce its rights under this subdivision is commenced within 6 years of the date that the health care item or service that is the subject of the claim was provided.

(4) IF A HEALTH COVERAGE RECIPIENT OF THE ENTITY IS ALSO A MEDICAL ASSISTANCE RECIPIENT, THE ENTITY SHALL NOT DENY A HEALTH CLAIM FOR WHICH MEDICAL ASSISTANCE PAYMENT HAS BEEN MADE SOLELY BECAUSE PRIOR AUTHORIZATION WAS NOT RECEIVED. WHERE THIS PRIOR AUTHORIZATION WAS NOT RECEIVED, THE ENTITY SHALL ADJUDICATE THE HEALTH CLAIM AS IF THE PRIOR AUTHORIZATION FOR THE CLAIM HAD BEEN REQUESTED.

SEC. 6. IF THE DEPARTMENT DETERMINES THAT A HEALTH COVERAGE RECIPIENT IS ALSO A CHILD SUPPORT ORDER DEPENDENT OR IS SUBJECT TO A CHILD SUPPORT ORDER, THE DEPARTMENT MAY SHARE INFORMATION RECEIVED UNDER SECTION 3 WITH THE DEPARTMENT OF HUMAN SERVICES TO ENABLE THE DEPARTMENT OF HUMAN SERVICES TO UPDATE ITS CHILD SUPPORT ORDER DATABASE.

Sec. 7. An entity that violates this act is subject to an administrative fine of not more than ~~$500.00~~ $750.00 for each day the entity does not comply with section 3(1) or with a request for information made pursuant to section 3(2). Upon the department's determination that a violation of this act has occurred, the entity has a right to notice of the alleged violation and an opportunity for a hearing under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328.

CITE-

42 USC Sec. *1396a*
01/05/2009

-EXPCITE-

TITLE 42 - THE PUBLIC HEALTH AND WELFARE

CHAPTER 7 - SOCIAL SECURITY

SUBCHAPTER XIX - GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

-HEAD-

Sec. 1396a. State plans for medical assistance

-STATUTE-

(a) Contents

A State plan for medical assistance must -

(25) provide -

(A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties (including health insurers, self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1167(1)]), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service) to pay for care and services available under the plan, including -

(i) the collection of sufficient information (as specified by the Secretary in regulations) to enable the State to pursue claims against such third parties, with such

information being collected at the time of any determination or redetermination of eligibility for medical assistance, and

(ii) the submission to the Secretary of a plan (subject to approval by the Secretary) for pursuing claims against such third parties, which plan shall be integrated with, and be monitored as a part of the Secretary's review of, the State's mechanized claims processing and information retrieval systems required under section 1396b(r) of this title;

(B) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability;

(C) that in the case of an individual who is entitled to medical assistance under the State plan with respect to a service for which a third party is liable for payment, the person furnishing the service may not seek to collect from the individual (or any financially responsible relative or representative of that individual) payment of an amount for that service (i) if the total of the amount of the liabilities of third parties for that service is at least equal to the amount payable for that service under the plan (disregarding section 1396o of this title), or (ii) in an amount which exceeds the lesser of (I) the amount which may be collected

under section 1396o of this title, or (II) the amount by which the amount payable for that service under the plan (disregarding section 1396o of this title) exceeds the total of the amount of the liabilities of third parties for that service;

(D) that a person who furnishes services and is participating under the plan may not refuse to furnish services to an individual (who is entitled to have payment made under the plan for the services the person furnishes) because of a third party's potential liability for payment for the service;

(E) that in the case of prenatal or preventive pediatric care (including early and periodic screening and diagnosis services under section 1396d(a)(4)(B) of this title) covered under the State plan, the State shall -

(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to the liability of a third party for payment for such services; and

(ii) seek reimbursement from such third party in accordance with subparagraph (B);

(F) that in the case of any services covered under such plan which are provided to an individual on whose behalf child support enforcement is being carried out by the State agency under part D of subchapter IV of this chapter, the State shall -

(i) make payment for such service in accordance with the usual payment schedule under such plan for such services

without regard to any third-party liability for payment for such services, if such third-party liability is derived (through insurance or otherwise) from the parent whose obligation to pay support is being enforced by such agency, if payment has not been made by such third party within 30 days after such services are furnished; and

(ii) seek reimbursement from such third party in accordance with subparagraph (B);

(G) that the State prohibits any health insurer (including a group health plan, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1167(1)], a self-insured plan, a service benefit plan, a managed care organization, a pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service), in enrolling an individual or in making any payments for benefits to the individual or on the individual's behalf, from taking into account that the individual is eligible for or is provided medical assistance under a plan under this subchapter for such State, or any other State;

(H) that to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished

to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services; and

(I) that the State shall provide assurances satisfactory to the Secretary that the State has in effect laws requiring health insurers, including self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1167(1)]), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service, as a condition of doing business in the State, to -

(i) provide, with respect to individuals who are eligible for, or are provided, medical assistance under the State plan, upon the request of the State, information to determine during what period the individual or their spouses or their dependents may be (or may have been) covered by a health insurer and the nature of the coverage that is or was provided by the health insurer (including the name, address, and identifying number of the plan) in a manner prescribed by the Secretary;

(ii) accept the State's right of recovery and the assignment to the State of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the State plan;

(iii) respond to any inquiry by the State regarding a claim for payment for any health care item or service that is submitted not later than 3 years after the date of the provision of such health care item or service; and

(iv) agree not to deny a claim submitted by the State solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if -

(I) the claim is submitted by the State within the 3-year period beginning on the date on which the item or service was furnished; and

(II) any action by the State to enforce its rights with respect to such claim is commenced within 6 years of the State's submission of such claim;

Title 42: Public Health

PART 433—STATE FISCAL ADMINISTRATION
Subpart D—Third Party Liability

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§ 433.138 Identifying liable third parties.

(a) *Basic provisions.* The agency must take reasonable measures to determine the legal liability of the third parties who are liable to pay for services furnished under the plan. At a minimum, such measures must include the requirements specified in paragraphs (b) through (k) of this section, unless waived under paragraph (l) of this section.

(b) *Obtaining health insurance information: Initial application and redetermination processes for Medicaid eligibility.* (1) If the Medicaid agency determines eligibility for Medicaid, it must, during the initial application and each redetermination process, obtain from the applicant or recipient such health insurance information as would be useful in identifying legally liable third party resources so that the agency may process claims under the third party liability payment procedures specified in §433.139 (b) through (f). Health insurance information may include, but is not limited to, the name of the policy holder, his or her relationship to the applicant or recipient, the social security number (SSN) of the policy holder, and the name and address of insurance company and policy number.

(2) If Medicaid eligibility is determined by the Federal agency administering the supplemental security income program under title XVI in accordance with a written agreement under section 1634 of the Act, the Medicaid agency must take the following action. It must enter into an agreement with CMS or must have, prior to February 1, 1985, executed a modified section 1634 agreement that is still in effect to provide for—

(i) Collection, from the applicant or recipient during the initial application and each redetermination process, of health insurance information in the form and manner specified by the Secretary; and

(ii) Transmittal of the information to the Medicaid agency.

(3) If Medicaid eligibility is determined by any other agency in accordance with a written agreement, the Medicaid agency must modify the agreement to provide for—

(i) Collection, from the applicant or recipient during the initial application and each redetermination process, of such health insurance information as would be useful in identifying legally liable third party resources so that the Medicaid agency may process claims under the third party liability payment procedures specified in §433.139 (b) through (f). Health insurance information may include, but is not limited to, those elements described in paragraph (b)(1) of this section; and

(ii) Transmittal of the information to the Medicaid agency.

(c) *Obtaining other information.* Except as provided in paragraph (l) of this section, the agency must, for the purpose of implementing the requirements in paragraphs (d)(1)(ii) and (d)(4)(i) of this section, incorporate into the eligibility case file the names and SSNs of absent or custodial parents of Medicaid recipients to the extent such information is available.

(d) *Exchange of data.* Except as provided in paragraph (l) of this section, to obtain and use information for the purpose of determining the legal liability of the third parties so that the agency may process claims under the third party liability payment procedures specified in §433.139(b) through (f), the agency must take the following actions:

(1) Except as specified in paragraph (d)(2) of this section, as part of the data exchange requirements under §435.945 of this chapter, from the State wage information collection agency (SWICA) defined in §435.4 of this chapter and from the SSA wage and earnings files data as specified in §435.948(a)(2) of this chapter, the agency must—

(i) Use the information that identifies Medicaid recipients that are employed and their employer(s); and

(ii) Obtain and use, if their names and SSNs are available to the agency under paragraph (c) of this section, information that identifies employed absent or custodial parents of recipients and their employer(s).

(2) If the agency can demonstrate to CMS that it has an alternate source of information that furnishes information as timely, complete and useful as the SWICA and SSA wage and earnings files in determining the legal liability of third parties, the requirements of paragraph (d)(1) of this section are deemed to be met.

(3) The agency must request, as required under §435.948(a)(6)(i), from the State title IV-A agency, information not previously reported that identifies those Medicaid recipients that are employed and their employer(s).

(4) Except as specified in paragraph (d)(5) of this section, the agency must attempt to secure agreements (to the extent permitted by State law) to provide for obtaining—

(i) From State Workers' Compensation or Industrial Accident Commission files, information that identifies Medicaid recipients and, (if their names and SSNs were available to the agency under paragraph (c) of this section) absent or custodial parents of Medicaid recipients with employment-related injuries or illnesses; and

(ii) From State Motor Vehicle accident report files, information that identifies those Medicaid recipients injured in motor vehicle accidents, whether injured as pedestrians, drivers, passengers, or bicyclists.

(5) If unable to secure agreements as specified in paragraph (d)(4) of this section, the agency must submit documentation to the regional office that demonstrates the agency made a reasonable attempt to secure these agreements. If CMS determines that a reasonable attempt was made, the requirements of paragraph (d)(4) of this section are deemed to be met.

(e) *Diagnosis and trauma code edits.* (1) Except as specified under paragraph (e)(2) or (l) of this section, or both, the agency must take action to identify those paid claims for Medicaid recipients that contain diagnosis codes 800 through 999 International Classification of Disease, 9th Revision, Clinical Modification, Volume 1 (ICD–9–CM) inclusive, for the purpose of determining the legal liability of third parties so that the agency may process claims under the third party liability payment procedures specified in §433.139(b) through (f).

(2) The agency may exclude code 994.6, Motion Sickness, from the edits required under paragraph (e)(1) of this section.

(f) *Data exchanges and trauma code edits: Frequency.* Except as provided in paragraph (l) of this section, the agency must conduct the data exchanges required in paragraphs (d)(1) and (d)(3) of this section in accordance with the intervals specified in §435.948 of this chapter, and diagnosis and trauma edits required in paragraphs (d)(4) and (e) of this section on a routine and timely basis. The State plan must specify the frequency of these activities.

(g) *Followup procedures for identifying legally liable third party resources.* Except as provided in paragraph (l) of this section, the State must meet the requirements of this paragraph.

(1) *SWICA, SSA wage and earnings files, and title IV-A data exchanges.* With respect to information obtained under paragraphs (d)(1) through (d)(3) of this section—

(i) Except as specified in §435.952(d) of this chapter, within 45 days, the agency must followup (if appropriate) on such information in order to identify legally liable third party resources and incorporate such information into the eligibility case file and into its third party data base and third party recovery unit so the agency may process claims under the third party liability payment procedures specified in §433.139 (b) through (f); and

(ii) The State plan must describe the methods the agency uses for meeting the requirements of paragraph (g)(1)(i) of this section.

(2) *Health insurance information and workers' compensation data exchanges.* With respect to information obtained under paragraphs (b) and (d)(4)(i) of this section—

(i) Within 60 days, the agency must followup on such information (if appropriate) in order to identify legally liable third party resources and incorporate such information into the eligibility case file and into its third party data base and third party recovery unit so the agency may process claims under the third party liability payment procedures specified in §433.139 (b) through (f); and

(ii) The State plan must describe the methods the agency uses for meeting the requirements of paragraph (g)(2)(i) of this section.

(3) *State motor vehicle accident report file data exchanges.* With respect to information obtained under paragraph (d)(4)(ii) of this section—

(i) The State plan must describe the methods the agency uses for following up on such information in order to identify legally liable third party resources so the agency may process claims under the third party liability payment procedures specified in §433.139 (b) through (f);

(ii) After followup, the agency must incorporate all information that identifies legally liable third party resources into the eligibility case file and into its third party data base and third party recovery unit; and

(iii) The State plan must specify timeframes for incorporation of the information.

(4) *Diagnosis and trauma code edits.* With respect to the paid claims identified under paragraph (e) of this section—

(i) The State plan must describe the methods the agency uses to follow up on such claims in order to identify legally liable third party resources so the agency may process claims under the third party liability payment procedures specified in §433.139 (b) through (f) (Methods must include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes.);

(ii) After followup, the agency must incorporate all information that identifies legally liable third party resources into the eligibility case file and into its third party data base and third party recovery unit; and

(iii) The State plan must specify the timeframes for incorporation of the information.

(h) *Obtaining other information and data exchanges: Safeguarding information.* (1) The agency must safeguard information obtained from and exchanged under this section with other agencies in accordance with the requirements set forth in part 431, subpart F of this chapter.

(2) Before requesting information from, or releasing information to other agencies to identify legally liable third party resources under paragraph (d) of this section the agency must execute data exchange agreements with those agencies. The agreements, at a minimum, must specify—

(i) The information to be exchanged;

(ii) The titles of all agency officials with the authority to request third party information;

(iii) The methods, including the formats to be used, and the timing for requesting and providing the information;

(iv) The safeguards limiting the use and disclosure of the information as required by Federal or State law or regulations; and

(v) The method the agency will use to reimburse reasonable costs of furnishing the information if payment is requested.

(i) *Reimbursement.* The agency must, upon request, reimburse an agency for the reasonable costs incurred in furnishing information under this section to the Medicaid agency.

(j) *Reports.* The agency must provide such reports with respect to the data exchanges and trauma code edits set forth in paragraphs (d)(1) through (d)(4) and paragraph (e) of this section, respectively, as the Secretary prescribes for the purpose of determining compliance under §433.138 and evaluating the effectiveness of the third party liability identification system. However, if the State is not meeting the provisions of paragraph (e) of this section because it has been granted a waiver of those provisions under paragraph (l) of this section, it is not required to provide the reports required in this paragraph.

(k) *Integration with the State mechanized claims processing and information retrieval system. Basic requirement—Development of an action plan.* (1) If a State has a mechanized claims processing and information retrieval system approved by CMS under subpart C of this part, the agency must have an action plan for pursuing third party liability claims and the action plan must be integrated with the mechanized claims processing and information retrieval system.

(2) The action plan must describe the actions and methodologies the State will follow to—

(i) Identify third parties;

(ii) Determine the liability of third parties;

(iii) Avoid payment of third party claims as required in §433.139;

(iv) Recover reimbursement from third parties after Medicaid claims payment as required in §433.139; and,

(v) Record information and actions relating to the action plan.

(3) The action plan must be consistent with the conditions for reapproval set forth in §433.119. The portion of the plan which is integrated with MMIS is monitored in accordance with those conditions and if the conditions are not met; it is subject to FFP reduction in accordance with procedures set forth in §433.120. The State is not subject to any other penalty as a result of other monitoring, quality control, or auditing requirements for those items in the action plan.

(4) The agency must submit its action plan to the CMS Regional Office within 120 days from the date CMS issues implementing instructions for the State Medicaid Manual. If a State does not have an approved MMIS on the date of issuance of the State Medicaid Manual but subsequently implements an MMIS, the State must submit its action plan within 90 days from the date the system is operational. The CMS Regional Office approves or disapproves the action plan.

(l) *Waiver of requirements.* (1) The agency may request initial and continuing waiver of the requirements to determine third party liability found in paragraphs (c), (d)(4), (d)(5), (e), (f), (g)(1), (g)(2), (g)(3), and (g)(4) of this section if the State determines the activity to be not cost-effective. An activity would not be cost-effective if the cost of the required activity exceeds the third party liability recoupment and the required activity accomplishes, at the same or at a higher cost, the same objective as another activity that is being performed by the State.

(i) The agency must submit a request for waiver of the requirement in writing to the CMS regional office.

(ii) The request must contain adequate documentation to establish that to meet a requirement specified by the agency is not cost-effective. Examples of documentation are claims recovery data and a State analysis documenting a cost-effective alternative that accomplished the same task.

(iii) The agency must agree, if a waiver is granted, to notify CMS of any event that occurs that changes the conditions upon which the waiver was approved.

(2) CMS will review a State's request to have a requirement specified under paragraph (l)(1) of this section waived and will request additional information from the State, if necessary. CMS will notify the State of its approval or disapproval determination within 30 days of receipt of a properly documented request.

(3) CMS may rescind a waiver at any time that it determines that the agency no longer meets the criteria for approving the waiver. If the waiver is rescinded, the agency has 6 months from the date of the rescission notice to meet the requirement that had been waived.

[52 FR 5975, Feb. 27, 1987, as amended at 54 FR 8741, Mar. 2, 1989; 55 FR 1432, Jan. 16, 1990; 55 FR 5118, Feb. 13, 1990; 60 FR 35502, July 10, 1995]

Title 42: Public Health

PART 433—STATE FISCAL ADMINISTRATION
Subpart D—Third Party Liability

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§ 433.139 Payment of claims.

(a) *Basic provisions.* (1) For claims involving third party liability that are processed on or after May 12, 1986, the agency must use the procedures specified in paragraphs (b) through (f) of this section.

(2) The agency must submit documentation of the methods (e.g., cost avoidance, pay and recover later) it uses for payment of claims involving third party liability to the CMS Regional Office.

(b) *Probable liability is established at the time claim is filed.* Except as provided in paragraph (e) of this section—

(1) If the agency has established the probable existence of third party liability at the time the claim is filed, the agency must reject the claim and return it to the provider for a determination of the amount of liability. The establishment of third party liability

takes place when the agency receives confirmation from the provider or a third party resource indicating the extent of third party liability. When the amount of liability is determined, the agency must then pay the claim to the extent that payment allowed under the agency's payment schedule exceeds the amount of the third party's payment.

(2) The agency may pay the full amount allowed under the agency's payment schedule for the claim and then seek reimbursement from any liable third party to the limit of legal liability if the claim is for labor and delivery and postpartum care. (Costs associated with the inpatient hospital stay for labor and delivery and postpartum care must be cost-avoided.)

(3) The agency must pay the full amount allowed under the agency's payment schedule for the claim and seek reimbursement from any liable third party to the limit of legal liability (and for purposes of paragraph (b)(3)(ii) of this section, from a third party, if the third party liability is derived from an absent parent whose obligation to pay support is being enforced by the State title IV-D agency), consistent with paragraph (f) of this section if—

(i) The claim is prenatal care for pregnant women, or preventive pediatric services (including early and periodic screening, diagnosis and treatment services provided for under part 441, subpart B of this chapter), that is covered under the State plan; or

(ii) The claim is for a service covered under the State plan that is provided to an individual on whose behalf child support enforcement is being carried out by the State title IV-D agency. The agency prior to making any payment under this section must assure that the following requirements are met:

(A) The State plan specifies whether or not providers are required to bill the third party.

(B) The provider certifies that before billing Medicaid, if the provider has billed a third party, the provider has waited 30 days from the date of the service and has not received payment from the third party.

(C) The State plan specifies the method used in determining the provider's compliance with the billing requirements.

(c) *Probable liability is not established or benefits are not available at the time claim is filed.* If the probable existence of third party liability cannot be established or third party benefits are not available to pay the recipient's medical expenses at the time the claim is filed, the agency must pay the full amount allowed under the agency's payment schedule.

(d) *Recovery of reimbursement.* (1) If the agency has an approved waiver under paragraph (e) of this section to pay a claim in which the probable existence of third party liability has been established and then seek reimbursement, the agency must seek recovery of reimbursement from the third party to the limit of legal liability within 60 days after the end of the month in which payment is made unless the agency has a waiver of the 60-day requirement under paragraph (e) of this section.

(2) Except as provided in paragraph (e) of this section, if the agency learns of the existence of a liable third party after a claim is paid, or benefits become available from a third party after a claim is paid, the agency must seek recovery of reimbursement within 60 days after the end of the month it learns of the existence of the liable third party or benefits become available.

(3) Reimbursement must be sought unless the agency determines that recovery would not be cost effective in accordance with paragraph (f) of this section.

(e) *Waiver of requirements.* (1) The agency may request initial and continuing waiver of the requirements in paragraphs (b)(1), (d)(1), and (d)(2) of this section, if it determines that the requirement is not cost-effective. An activity would not be cost-effective if the cost of the required activity exceeds the third party liability recoupment and the required activity accomplishes, at the same or at a higher cost, the same objective as another activity that is being performed by the State.

(i) The agency must submit a request for waiver of the requirement in writing to the CMS regional office.

(ii) The request must contain adequate documentation to establish that to meet a requirement specified by the agency is not cost-effective. Examples of documentation are costs associated with billing, claims recovery data, and a State analysis documenting a cost-effective alternative that accomplishes the same task.

(iii) The agency must agree, if a waiver is granted, to notify CMS of any event that occurs that changes the conditions upon which the waiver was approved.

(2) CMS will review a State's request to have a requirement specified under paragraph (e)(1) of this section waived and will request additional information from the State, if necessary. CMS will notify the State of its approval or disapproval determination within 30 days of receipt of a properly documented request.

(3) CMS may rescind the waiver at any time that it determines that the State no longer meets the criteria for approving the waiver. If the waiver is rescinded, the agency has 6 months from the date of the rescission notice to meet the requirement that had been waived.

(4) An agency requesting a waiver of the requirements specifically concerning either the 60-day limit in paragraph (d)(1) or (d)(2) of this section must submit documentation of written agreement between the agency and the third party, including Medicare fiscal intermediaries and carriers, that extension of the billing requirement is agreeable to all parties.

(f) *Suspension or termination of recovery of reimbursement.* (1) An agency must seek reimbursement from a liable third party on all claims for which it determines that the amount it reasonably expects to recover will be greater than the cost of recovery. Recovery efforts may be suspended or terminated only if they are not cost effective.

(2) The State plan must specify the threshold amount or other guideline that the agency uses in determining whether to seek recovery of reimbursement from a liable third party, or describe the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.

(3) The State plan must also specify the dollar amount or period of time for which it will accumulate billings with respect to a particular liable third party in making the decision whether to seek recovery of reimbursement.

[50 FR 46665, Nov. 12, 1985, as amended at 51 FR 16319, May 2, 1986; 60 FR 35503, July 10, 1995; 62 FR 23140, Apr. 29, 1997]